Authorization for Use and Disclosure
of Private Health Information

Maricopa Integrated Health System, Inc.-Health Plans (MIHS-HP)

Purpose: This form is used to obtain an individual's consent to MIHS-HP's use and disclosure of an individual's protected health information to carry out MIHS-HP's payment and treatment activities as well as health care operations.

Member Name :_____

Address:_____

Telephone Number:_____

Member ID Number:_____

1. I authorize the use or disclosure of the above named individual's protected health information for the purpose of carrying out payment, treatment and health care operations activities.

2. This information may be disclosed to and used by the following organization:

   Maricopa Integrated Health System-Health Plans
   2502 East University Drive, Ste. 202
   Phoenix, AZ 85034

3. I understand that my protected health information may include information related to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and genetic testing.

4. I understand that I have the right to revoke this authorization at any time. I understand that to revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition:_____.

5. I understand that signing this authorization form is voluntary. I can refuse to sign this authorization. I need not sign this form to receive benefits. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by privacy rules. If I have questions about disclosure of my health information, I can contact:

   Maricopa Integrated Health System-Health Plans - Member Services
   2502 East University Drive, Suite 202
   Phoenix, AZ 85034
   Telephone: 602-344-8760, Toll-Free: 1-800-582-8686, TDD (hearing impaired): 602-344-8789

Member Signature:_____ **Date:**_____

A copy of this form will be submitted to the MIHS-HP Compliance Department.